

response date three (3) months from November 28, 1996 to February 28, 1997.

Please amend the Application as follows:

IN THE SPECIFICATION

Page 41, line 1, change "COMMON" to -- CURRENT --;

Page 45, line 1, change "COMMON" to -- CURRENT --;

IN THE CLAIMS

Please amend the claims as follows:

1. (Amended) A documentation system comprising
- a preprinted form having a plurality of recording sections wherein each one of said plurality of recording sections is assigned as a discrete recording section for a designated condition in a selected printed format for recording information relating to its associated designated condition;
- a recording [person] means for recording on the preprinted format and in the appropriate discrete recording section one of a predetermined encoded indicia representing information developed for a designated condition;
- an input member [used by said recording person] responsive to said recording means for recording information specific to the designated condition communicated to said recording [person] means [by a first person], said information being recorded [by said recording person] in the form of encoded indicia in at least one discrete recording section of said [recording] input member;

a transcriber [which is] responsive to [the preprinted format containing the] said encoded indicia for providing at least one report section template corresponding to the discrete recording section for its associated designated condition, said report section comprising optional text variable segments each of which are assigned to one of said predetermined encoded indicia, said transcriber being responsive to said encoded indicia recorded in said at least one discrete report section to decode the optional text variable segment assigned to one of the predetermined encoded indicia; and

a' a report prepared by the transcriber which is specific to each designated condition comprising optional text variable segments documenting the designated condition.

2. (Amended) A medical documentation system comprising apparatus for recording information relating to at least one of a designated patient's current medical condition, a physical examination, a diagnosis and a treatment plan;

an input device operative with said apparatus for recording medical information communicated by a first person to a second person during a physical examination of the designated patient, said information being recorded by said [first] second person on the apparatus in the form of predetermined encoded indicia; and

a processor having at least one report section template corresponding to one of a patient's current medical condition, a patient's physical examination, a patient's diagnosis and a

a1
cont.
patient's treatment plan, said at least one report section template comprising optional text variable segments each of which are assigned to a selected one of said predetermined encoded indicia, said processor being operative to decode each of said one of the predetermined encoded indicia into its assigned optional text variable segment in said at least one discrete recording section and storing the same in a retrievable format.

a2
7. (Amended) A medical documentation system comprising:
a recording member having a plurality of recording sections formed thereon for recording information relating to at least one of a designated patient's current medical condition, a physical examination, a diagnosis and a treatment plan;

an input member for recording medical information communicated by a first person to a second person during a physical examination of the designated patient, said information being recorded by said second person in the recording member in the form of predetermined encoded indicia in at least one recording section of said recording member;

a computer having a plurality of report section templates stored therein including a first report section template corresponding to a recording section for the patient's current medical condition, a second report section template corresponding to a recording section for the patient's physical examination, a third report section template corresponding to a recording section for the patient's diagnosis and a fourth report section

template corresponding to a recording section for the patient's treatment plan, each of said report section templates comprising optional text variable segments each of which are assigned to a selected one of said predetermined encoded indicia; [,]

Q2 said computer being operative to decode each of said one of the predetermined encoded indicia recorded in the recording member into the assigned optional text variable segment in each applicable discrete recording section and storing the same in a retrievable memory location; and

an imaging member responsive to the computer for preparing a patient's report specific to the designated patient's at least one of medical condition, physical examination, diagnosis and treatment plan comprising the optional text variable segments stored at retrievable memory locations.

17. (Amended) A medical history documentation system comprising:

A3 a recording member having a plurality of discrete recording sections formed thereon, each of said discrete recording sections being programmed to record information relating to at least one of a designated patient's current medical condition, a physical examination, a diagnosis and a treatment plan;

an input member for recording medical information verbally communicated by a first person to a second person during a physical examination of the designated patient, said information being recorded on the recording member by said second person in

the form of predetermined encoded indicia in at least one discrete recording section of said recording member;

a transcriber for providing a plurality of report section templates including a first report section template corresponding to a discrete recording section for the patient's current medical condition, a second report section template corresponding to a discrete recording section for the patient's physical examination, a third report section template corresponding to a discrete recording section for the patient's diagnosis and a fourth report section template corresponding to a discrete recording section for the patient's treatment plan, each of said report section templates comprising a plurality of optional text variable segments each of which are assigned to a selected one of said predetermined encoded indicia, said transcriber being operative to decode each of said one of the predetermined encoded indicia recorded on said recording member into the optional text variable segment assigned thereto for each applicable discrete recording section; and

an imaging device responsive to the transcriber for preparing a patient's report specific to the designated patient comprising a combination of selected optional text variable segments for a designated patient's at least one of medical condition, physical examination, diagnosis and treatment plan.

21. (Amended) A method for documenting information for a designated condition comprising the steps of:

conducting by a first person an examination of a designated condition in accordance with an examination procedure wherein the first person during the examination of the designated condition communicates first information of the condition to be documented;

recording by a second person [with] on a recording device in a predetermined format [the] said first information of the [communicated] condition communicated by the first person during the examination of the designated condition resulting in recorded indicia;

af
cont. processing [the information] said recorded indicia [by the recording device] to produce in a programmable format a patient report containing the information of the designated condition; and

comparing said patient report and said recorded indicia [the information of the designated condition on the report with the information of the condition recorded by the recording device] to verify the accuracy of the information.

22. (Amended) A method for documenting verified patient medical information for a patient's history file comprising the steps of:

conducting by a first person a physical examination of a patient in accordance with an examination procedure wherein the first person during the physical examination of the patient communicates the patient medical information to be documented;